CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 1, 2011

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Department of Health Care Services
Sacramento, CA 95899

Submitted Electronically at omcprfp9@dhcs.ca.gov

SUBJECT: Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare

Dear Mr. Morrill:

The California Hospital Association (CHA), representing more than 400 hospitals and health systems throughout California, respectfully submits responses to questions posed to stakeholders in the recently released request for information (RFI) on pilots for beneficiaries who are dually eligible for Medi-Cal and Medicare.

CHA member hospitals operate hundreds of medical programs and services, including acute-care hospitals, inpatient rehabilitation facilities (IRFs), long-term acute-care hospitals, hospital-based skilled-nursing facilities (SNFs) and home health agencies. Our member organizations also operate or partner with numerous home and community-based services, including clinics, adult day health centers and others. The collective goal of all of these providers is to support the individual in achieving and maintaining optimal health status and independence.

CHA supports the development of systems of care and care management that will provide adequate beneficiary access to medical care at all levels of the patient-care continuum. The prospect of developing an integrated-care model holds promise for improving beneficiary access to care and care coordination, and improving overall health status.

The medical and rehabilitative care provided by our member hospitals and health systems is critical to each individual's successful recovery and ability to live with and manage chronic illness or disability. We appreciate the opportunity to provide input on this process through membership in the technical advisory group, and we look forward to continuing that work as the planning and implementation process continues.

On behalf of our members, the following provides responses to the Questions for Interested Parties requested in the RFI.

1. What is the best enrollment model for this program?

CHA opposes the mandatory enrollment of Medicare beneficiaries into managed care. Enrollment into the managed care entity should be conducted through a voluntary, "opt-in" approach for dually eligible individuals, or "Medi-Medi's." If any level of mandatory enrollment is pursued, it must be applicable only to the individual's Medi-Cal benefit. Beneficiaries could then be given the opportunity to voluntarily enroll for management of their Medicare benefit based on their individual needs and preferences. There are several reasons we advocate for this approach.

- A hallmark of the Medicare program is the preservation of patient choice for coverage options and providers. The enrollment of dual eligibles into managed care must be conducted in such a way as to preserve the individual's ability to actively exercise that choice. Dually eligible individuals are "Medicare first" for access to providers and medical care, and the enrollment process must recognize that. Moreover, an active enrollment process maximizes the opportunity for beneficiaries to make informed decisions regarding how and where they receive their medical care.

- An active enrollment process will support continuity of care. Because "Medi-Medi's" receive the majority of their medical care via their Medicare benefit, many receive services from physicians and hospitals that do not contract with Medi-Cal, and/or with the participating plan. An active enrollment process, in which the patient makes an informed choice to enroll, would allow for adequate communication and planning when a change in care provider is necessary. In our view, widespread mandatory enrollment will result in confusion and disruptions in care transitions.

- We also recommend that the enrollment process be designed in a way that increases the number of covered members on a gradual basis. At present, the availability and capacity of medical providers contracted with Medi-Cal or specific managed care plans is very limited. In many regions of the state, only one hospital and few physicians contract with Medi-Cal or any of the Medi-Cal managed care plans. A rapid enrollment of new members will almost certainly overwhelm the capacity of existing networks. A gradual enrollment process will allow a participating plan sufficient time to build a network adequate to meet the needs of its enrollees.

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

- It is essential that the model provide adequate access to rehabilitative care and therapy services. Individuals may be able to remain or return to greater independence and a community setting if they receive adequate therapy, in particular for functional mobility and activities of daily living.

- Adequate and timely access to durable medical equipment, including both mobility aids and adaptive equipment to support independence, will support individuals' ability to remain independent or in the least expensive appropriate care setting.

- Support and training for caregivers, including informal caregivers such as family members, and professional caregivers will maximize the opportunity for reaching and maintaining maximum health care status and functional independence.

- Ongoing support for behavioral health issues, including both mental health issues and substance abuse disorders, is also essential. Such services must be available to individuals with a primary mental health or substance-abuse diagnosis, but also should be readily available and accessible to beneficiaries with primary medical diagnoses.

- Long-term institutional care, when necessary, should be included in the model. While beneficiaries should be able to remain in their homes or other community-based settings whenever possible, there are times when long-term care in a facility setting may be necessary, secondary to the individual's medical needs and adequacy of the home and availability of supervision or care-giving resources. In these cases, beneficiaries should have access to a choice of providers that will meet their specific medical needs and support the highest quality of life possible. In addition, designing the model to include long-term institutional care will incentivize the managed care entity to minimize the need for such services though improved care coordination and access to essential primary medical care and transitional and rehabilitative services.

3. How should behavioral health services be included in the integrated model?

- Behavioral health services should be fully integrated in the model, in accordance with federal parity law.

- Both mental health (MH) and substance-use disorders (SUD) must be clearly included as provided/covered services.

4. If you are a provider of long-term supports and services, how would you propose participating in an integration pilot? What aspects of your current contract and reimbursement arrangement would you want to keep intact, and what could be altered in order to serve as a subcontractor for the contracted entities?

Not Applicable.

5. Which services do you consider to be essential to a model of integrated care for duals?

- Adequate network capacity to medical-care providers, including primary-care providers, medical specialists, and institutional providers is essential. Beneficiaries must continue to have access to the same mainstream providers from whom they received their care prior to enrollment. Critical to this effort will be the maintenance of adequate reimbursement rates for all medical providers.

- Case management services: Case management services should include both medical case management addressing the individual's access to and utilization of medical services, and community-based case management to provide assistance in obtaining other services that will support the individual patient's success (e.g., transportation). Case management services should include an emphasis on transitions of care among and between all care settings.

- Disease management services: Many dually eligible individuals have chronic diseases which, if not managed effectively, lead to decreases in health status, disability and increased costs of care. An effective care model will include specialized disease management programs for such conditions.

- Access to community-based medical services, including home health care, is essential. The lack of medical services in the community setting can be a major barrier to an individual's ability to reside in the community. For example, in many parts of the state, Medi-Cal beneficiaries do not have access to home health services, effectively mandating that they enter a SNF or hospital to obtain necessary medical care.

- Access to transitional and rehabilitative care is essential. Many patients unable to return home directly from a stay in the acute-care hospital will be able to do so after a short stay in a post-acute-care facility, such as an IRF or SNF. Similarly, access to therapy services through a home health care agency or on an outpatient basis will also support achievement and maintenance of optimal independence and health status.

- Regular "well" assessments and medical check-ups should be included. Monitoring the physical, functional and cognitive status of enrollees on a regular basis will allow care providers to identify problems and concerns before they evolve and become more serious and costly.

- Preventative-care services are essential.

- Telepsychiatry and crisis-stabilization services are essential.

6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?

- At enrollment, beneficiaries should be provided with clear information about the plan, including significant differences from fee-for-service Medicare and how services are accessed. A list of available medical care providers, including physicians and hospitals, should be included as part of this information.

- Beneficiaries should receive comprehensive information regarding their rights and responsibilities, including that "Medi-Medi's" retain the full range of Medicare benefits. Clear information regarding enrollment and dis-enrollment options should be provided.

- Both beneficiaries and providers should be provided with information regarding procedures for filing appeals for service and/or claim denials, and for problem resolution.

- Providers should be given a detailed outline of the plan and timeline to move dual eligibles into this pilot project. In association with this transition, sufficient response time should be allowed for feedback from the providers before any change is implemented. There should also be an "open-enrollment" period for facilities and providers to contract with the managed care plan prior to implementation. Providers should also be provided with data detailing the number of potential dual eligibles in their catchment areas, including a breakdown by the following categories:
    - Seniors, including a break out of those with disabilities, chronic health conditions and behavioral health diagnoses.
    - Non-senior adults with break out of each of the above.
    - Children with break out of each of the above.

7. What questions would you want a potential contractor to address in response to a Request for Proposals?

- How will newly enrolled patients be assigned to primary-care physicians and other providers? What steps will be taken to ensure individual beneficiaries can remain with their current primary-care provider?

- What steps have been taken to ensure adequate network capacity? This question should be addressed in a number of categories, including primary care, specialty care, behavioral health services, home health, skilled-nursing care, etc.

- In the case where a beneficiary requires specialized care not available in your network or where patient demand exceeds network capacity, how will you meet that need (for example, specialized burn care)?

- How will you facilitate service availability and provider payments for patients who must cross county lines to obtain services? For example, at present 30 counties have no inpatient acute psychiatric-care services, and patients must travel to other counties to access that care.

8. Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries?

- All services must be provided in a manner consistent with standards established by the Centers for Medicare & Medicaid Services (CMS) for the provision of medical care, and with California state law. Clinical care should be guided by medical necessity determinations consistent with Medicare standards and policy.

- Contractors must be able to provide evidence that they are able to provide meaningful and timely access to all levels of necessary care.

- Contractors must have sufficient data-collection and -analysis capabilities to provide timely and comprehensive information regarding enrollee health status and utilization, as required.

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

CHA is prepared to play an active role in providing timely information to our member providers, and will actively work with the Department of Health Care Services to identify issues and resolve problems as they arise.

10. What concerns would need to be addressed prior to implementation?

- Development of sufficient provider networks in all areas of care, including identification of care providers willing and able to accept enrollees for care.

- Development of reimbursement and rates for medical services. The development of adequate rates will be critical to the managed care entity's ability to recruit sufficient number and range of medical providers and to build an adequate network for their enrollees. At a minimum, reimbursement rates for medical services must be equal to Medicare reimbursement rates.

- Provision of information to providers, both participating and non-participating, to ensure adequate preparation and awareness of changes in beneficiary coverage.

11. How should the success of these pilots be evaluated, and over what timeframe?

- Measures should include both medical and functional outcome measures, as well as a measure addressing the number/percentage of individuals who are able to continue residing independently and/or in the community.
- Data collection should be standardized to allow comparisons among and between plans and pilots, as well as comparisons between pilot and non-pilot counties.
- Patients/beneficiaries should be asked to report on their experience of care, including ability to access services and have input into care decisions.
- Providers should be asked about their experience working with the managed care entity, in regards to both administrative procedures and clinical care.
- Evaluation and data collection should take place annually, and tracked over several years.
- Expansions of the initial pilots should not be pursued until the initial pilot programs have been thoroughly evaluated and necessary changes and program improvements can be identified.

12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

- Reimbursement and provider rates must be sufficient to ensure that an adequate number of providers participate in the plan.

Thank you again for the opportunity to submit these comments. CHA supports the state's efforts to develop new and creative models of health care delivery and reimbursement, and we look forward to working together on this important initiative.

Sincerely,

Patricia L. Blaisdell
Vice President, Post-Acute-Care Services